EXHIBIT A

.135

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

WILLIAM DAVID SEAL **PLAINTIFF**

V. **CIVIL ACTION NO. 1:08CV175-LG-RHW**

HARRISON COUNTY, MISSISSIPPI BY AND THROUGH ITS BOARD OF SUPERVISORS; GEORGE PAYNE; WAYNE PAYNE; DIANE GASTON RILEY; STEVE CAMPBELL; RICK GASTON; RYAN TEEL, PRESTON WILLS, CORRECTIONS OFFICERS JOHN DOES 1-2; AMERICAN CORRECTIONS ASSOCIATION; JAMES A. GONDLES, JR.; AMERICAN CORRECTIONS ASSOCIATION EMPLOYEES JOHN AND/OR JANE DOES 1-3,; HEALTH ASSURANCE LLC; HEALTH ASSURANCE, LLC EMPLOYEES JOHN AND/OR JANE DOES 1-2

DEFENDANTS

FIRST SET OF INTERROGATORIES PROPOUNDED TO PLAINTIFF BY THE DEFENDANT, WAYNE PAYNE, IN HIS OFFICIAL AND INDIVIDUAL CAPACITIES

COMES NOW Defendant, Wayne Payne, in his official and individual capacities, by and through his attorneys, Dukes, Dukes, Keating and Faneca, P.A., and pursuant to Federal Rules of Civil Procedure and hereby propounds the following discovery unto the Plaintiff, William David Seal, by way of Interrogatories. This discovery is continuing in nature and requires you to file supplemental answers in accordance with the Federal Rules of Civil Procedure if you obtain further or different information after submission of your initial answers before trial, including in each supplemental answer the date and manner in which you became aware of the additional information. The Interrogatories

are propounded as follows, to-wit:

INTERROGATORY NO. 1: If you are alleging any emotional distress claim or other mental health injuries as a result of the allegations contained in your Complaint, please state whether you have ever received any treatment for any type of mental health problems prior to or after September 4 - 6, 2005. If so, please identify by name, address, and telephone number each and every individual, physician, social worker or mental health provider and/or and facility which provided treatment, the dates of such treatment, and a detailed description of any diagnoses made.

INTERROGATORY NO. 2: List the names and addresses of any and all physicians and other health care or mental health care providers who examined or treated you for any illnesses claimed by you as a result of the incidents described in your Complaint, stating the dates of treatment, reasons for each visit and any diagnoses rendered.

INTERROGATORY NO. 3: Please identify each and every hospital, clinic, medical facility, or mental health facility at which you have been examined, confined, or treated for any injury or condition claimed by you to be the result of the incidents alleged in your Complaint, and please list as to each such facility its complete name, address, and dates of treatment.

INTERROGATORY NO. 4: Please describe in detail any and all injuries you allege to have suffered as a result of this incident. Including in your description any and all medical, physiological, mental health, or other treatment you have received or continue to receive as a result of this incident, including the names and addresses of

any and all physicians, hospitals, physiologists, counselors, or other health care providers rendering treatment.

INTERROGATORY NO. 5: Please provide an itemized and detailed list of damages which you claim to have suffered as a result of the incidents alleged in your Complaint, and please identify in this list each and every piece of evidence which you contend support your claims.

INTERROGATORY NO. 6: State with specificity, the amount claimed for each element of damage set forth in your general prayer for relief in your Complaint, specifically, an itemization of medical costs, to whom said cost(s) are owed and whether or not costs have been paid by or on your behalf.

INTERROGATORY NO. 7: Please state whether you contend to have sustained any loss of income or any loss of wage earning capacity? If so, please provide the amount of loss of income, list your monthly gross and net income, state the name and address of any and all employer(s), and state with specificity the facts, circumstances and list any and all documents which support your contention of loss of wage earning capacity as set forth in your Complaint.

INTERROGATORY NO. 8: Please identify each Harrison County Sheriff's Department employee who you allege knew or should have known that you were in need of medical care, denied you medical care, and identify each person and document which you contend support this allegation as set forth in your Complaint.

INTERROGATORY NO. 9: In your Complaint you allege that there were elected officials and appointed officials with final policy making authority who you allege

were aware of the existence of habit, pattern, custom, and/or policy of the use of intentional injurious excessive force against inmates/detainees at the Harrison County Detention Facility prior to September 4 - 6, 2005. Regarding these allegations, please set forth the individuals involved, and the factual basis which you contend support these allegations and state the full name, area of specialty, expertise, complete address and telephone number of each person, including expert(s), who has or may have knowledge of the facts or opinions which you contend support these allegations. Furthermore, identify and give a description of each document, treatise, journal, article, publication, or any other documentation which you or your expert(s) relies upon to support these allegations.

INTERROGATORY NO. 10: Please identify each Harrison County Sheriff's Department employee who you allege neglected to report alleged abuse of inmates/detainees at the Harrison County Adult Detention Center, and identify each person by name and/or document which you believe may have facts or information to support the allegation as set forth in your Complaint.

INTERROGATORY NO. 11: Please identify each Harrison County Sheriff's Department employee, elected officials and all appointed officials of the Harrison County Sheriff's Department, who you believe participated in an alleged conspiracy to cover up the alleged abuse of inmates/detainees at the Harrison County Adult Detention Center, and identify each person by name and/or document which you believe may have facts or information to support the allegation as set forth in your Complaint.

INTERROGATORY NO. 12: Please provide any and all facts or information to support your allegation that Sheriff Payne and/or any other final policy maker at the Harrison County Adult Detention Center failed to properly train and/or supervise the officers and supervisors, and identify any and all documentation which you believe contains supportive information as to said allegation(s) as stated in your Complaint.

INTERROGATORY NO. 13: Please identify any and all individuals who may have discoverable knowledge and information about the claims made in your Complaint and provide the business and/or residential addresses and telephone numbers for each.

INTERROGATORY NO. 14: Please identify those individuals from whom a written, recorded, transcribed or oral statement has been obtained by you, your attorneys, agents or by anyone working in connection with this case on your behalf regarding the allegations and claims as stated in your Complaint.

INTERROGATORY NO. 15: Specify in detail each and every injury or element of damage which you contend you sustained or suffered as a result of the incident described in your Complaint and in connection therewith, give the following specific information:

a. A specific description of each injury or element of damage;

b. An itemization of the monetary value of each injury or element of damage;

c. An itemization of the medical expenses incurred, which you allege are associated with the alleged injuries and which, if any, you

believe that you are responsible for; and

d. Any other associated expenses and/or damage(s) you intent to seek at the trial of this matter.

INTERROGATORY NO. 16: Please identify each and every individual who may be called at the trial of this matter and indicate whether they will give opinion testimony.

INTERROGATORY NO. 17: Identify any and all medical articles, text, treatise or publications which are either relied upon by you and/or any expert witness retained by you to support your claim against any Defendant as stated in your Complaint. Specifically, state the exact title, name, and/or issue, the authors, the date of publication, and the specific pages and statements relied upon.

INTERROGATORY NO. 18: Please describe any prior injury or condition which is similar to or was in a similar location to any of the injuries you complained of as a result of the occurrence stated in your Complaint, including the following information:

a.. date of injury or onset;

b. the cause or source;

c. identify of each physician or healthcare provider who has provided you, or who is scheduled to provide you with, care or treatment in connection with the same; and

d. your place of employment and name of supervisor at time of each condition or injury.

INTERROGATORY NO. 19: If you have received workers compensation benefits, private insurance benefits, social security benefits, Medicare, Medicaid or

other such payment which will or may require a subrogation or repayment by Defendants in the event of any recovery, please state the amount of each such payment, the person making such payment and state whether subrogation or repayment would be required or requested.

INTERROGATORY NO. 20: Identify fully each and every physician and/or practitioner of the healing arts you have seen since the incident described in your Complaint, and specifically describe the reason such professional was seen, as well as the diagnosis and any and all medications yo have used for the injuries alleged by you in your Complaint. Additionally, identify each and every drug store or pharmacy you have obtained medications from since the date of the incident described in your Complaint.

RESPECTFULLY SUBMITTED, this the 2 day of February, 2009.

WAYNE PAYNE, DEFENDANT

BY: DUKES, DUKES, KEATING & FANECA, P.A.

BY: _____
CY FANECA

CERTIFICATE OF SERVICE

I, CY FANECA, do hereby certify that I have this day sent via U.S. Mail a true and correct copy of the foregoing to the following:

Counsel for Plaintiff:
Robert G. Harenski
1906 Pass Road
Biloxi, MS 39531

Counsel for Harrison County:
Joseph R. Meadows, Esq.
Post Office Drawer 550
Gulfport, MS 39502

This, the 2 day of February, 2009.

CY FANECA

CY FANECA, MSB #5128
HALEY N. BROOM, MSB #101838
JOE C. GEWIN, MSB #8851
DUKES, DUKES, KEATING & FANECA, P.A.
POST OFFICE DRAWER W
GULFPORT, MISSISSIPPI 39502
TELEPHONE - (228) 868-1111
FACSIMILE - (228) 863-2886

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DEFENDANTS

FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS
PROPOUNDED TO THE PLAINTIFF BY DEFENDANT GEORGE PAYNE, JR.

COMES NOW, the Defendant, George Payne, Jr. , in his official and individual capacities, by and through his attorneys, Dukes, Dukes, Keating and Faneca, P.A., by way of Requests for Production of Documents in accordance with the Federal Rules of Civil Procedure, and does hereby propound the following discovery unto the Plaintiff, William David Seal, and requests that same be answered in the manner prescribed by law.

In the following Request for Production of Documents:

"You" and "your" means Plaintiff and all representatives, attorneys and other parties acting on behalf of the Plaintiff.

The term "Document" shall be broadly construed to include, without limitation,

every writing, drawing, chart, photograph, or any other type of retrievable compiled data, including electronic data or digital data, electronic images contained in a tangible medium, electronically stored information contained within any computer network, personal computer, personal digital assistant, cellular telephone, or other medium, as well as accompanying attachments and appendices. For purposes of these requests, any draft or revision of a document, transcript or record of conversation, or any document or copy of a document which contains any annotation, addition, deletion, or otherwise comprises a non-identical copy of another document shall be treated as a separate document subject to production.

These Requests for Production of Documents shall be deemed continuing so as to require supplemental answers if you obtain further information between the time responses are served and the trial of this matter.

REQUEST NO. 1: Please produce all documents that you identified, referenced, relied upon in any way in either your Complaint or in your responses to Interrogatories propounded to Plaintiff by Defendants George Payne, Jr., Wayne Payne and Dianne Gatson-Riley.

REQUEST NO. 2: Please produce a copy of all documents, photographs, video tapes and/or other demonstrative evidence which you will or may offer as evidence at the trial of this cause.

REQUEST NO. 3: Please produce copies of any documents, containing any information relevant to the issues raised in this case.

REQUEST NO. 4: Please produce copies of the reports of all expert witnesses you propose to use at the trial of this cause.

REQUEST NO. 5: Please furnish reports of all expert consultants you have retained or employed to assist you in preparing this case for trial.

REQUEST NO. 6: Please produce a copy of the curriculum vitae of all expert witnesses you propose to use at the trial of this cause.

REQUEST NO. 7: For each expert witness identified by you in your responses to Interrogatories, please produce a copy of every document or tangible item relied upon by each such expert in the formulation of their opinions, to include a copy of each such expert's file regarding this matter.

REQUEST NO. 8: Please furnish a detailed itemization of all injuries and damages which you claim to have sustained as a result of the conduct of the Defendants herein.

REQUEST NO. 9: Please produce a copy of any and all medical reports and records of physicians who have previously or are currently rendering treatment to you as a result of any illnesses or injuries, including but not limited to any illnesses or injuries allegedly sustained as a result of the incident giving rise to this lawsuit as stated in your Complaint.

REQUEST NO. 10: Please produce a copy of all hospital records, clinical records, outpatient records, X-rays, nursing notes and other such records prepared in connection with the treatment of the Plaintiff for the injuries alleged in your Complaint.

REQUEST NO. 11: Please produce any and all copies of incident reports or reports of an investigation which you may have in your possession which described or investigated the incident alleged in your Complaint or other pleadings.

REQUEST NO. 12: Please produce copies of all grievances and inmate requests

filed by you while incarcerated in the Harrison County Adult Detention Center.

REQUEST NO. 13: Please produce a copy of Plaintiff's Federal and State Income Tax Returns for the previous five (5) years. Please sign and return the enclosed IRS Authorization Form.

REQUEST NO. 14: Please sign the Request for Social Security Earnings Information attached hereto.

REQUEST NO. 15: Please produce copies of any and all letters or other correspondence that you sent to any of the Defendants identified in your Complaint.

REQUEST NO. 16: Please produce copies of any and all reports or statements, signed or otherwise, given or made by you concerning this lawsuit, or concerning any of your allegations which are the subject of this lawsuit.

REQUEST NO. 17: Please provide with your responses to these requests an authorization form signed by Plaintiff which authorizes the Defendants and their agents and attorneys to obtain any and all medical reports, medical records, X-rays, X-ray reports, laboratory reports, nurses' notes, physicians' orders, mental health notes, or records of mental health treatment, and any and all other documents relating to your medical and/or emotional condition which you have received from any physician, doctor, hospital or any other provider of medical or mental health services.

Please execute the attached HIPPA Medical Authorization form and in doing so, please completely fill out the medical authorization providing all information requested therein and initializing in the appropriate spaces where indicated. (Please note that the attached medical authorization is intended to comply with HIPPA.)

REQUEST NO. 18: Please produce copies of any and all statements which you

may have obtained from Defendants George Payne, Jr., Wayne Payne, Dianne Gatson-Riley, and Steve Campbell or any of their agents, employees or representatives which in any way related to any incident alleged in Plaintiff's Complaint.

REQUEST NO. 19: Please execute the attached employment authorization, which authorizes Defendants or their attorneys to obtain records of your past employment.

REQUEST NO. 20: Please produce all documents or other tangible things which you intend to use, in any manner, at trial of this matter.

REQUEST NO. 21: Please produce all information, documents, photographs, electronic images, and or recordings, videotapes and any other tangible things that your contend to support your allegation that there existed habit, pattern, custom, or policy of the use of intentional injurious excessive force against inmates/detainees within the Harrison County Adult Detention Center.

REQUEST NO. 22: Please produce all information, documents, photographs, electronic images, and or recordings, videotapes and any other tangible things that you contend support your allegation that elected officials and appointed officers with final policy making authority of the Harrison County Sheriff's Department had knowledge of the alleged habit, pattern, custom, or policy of the use of intentional injurious excessive force against inmates/detainees at the Harrison County Adult Detention Center in direct violation against federally mandated constitutional protections afforded to citizens and other persons so incarcerated.

REQUEST NO. 23: Please produce a copy of any and all documents which support your allegations that there were violations of the 1995 Consent Decree.

REQUEST NO. 24: Please produce copies of any and all documents which you allege support your claim for excessive force as stated in your Complaint.

REQUEST NO. 25: Please produce a copy of any and all documents which you allege support your allegation that Defendants conspired to deprive you and other inmates at the HCADC of "professional medical care and related health care services to inmates and detainees at the HCADC", as stated in your Complaint.

REQUEST NO. 26: Please produce any and all copies of documents which you believe support your allegation that Defendants engaged in a "conspiratorial scheme to camouflage, cover up, falsely explain and/or deny what in truth and in fact happened to the Plaintiff".

REQUEST NO. 27: Please provide any and all documentation and/or communication, whether oral or written, which you believe supports your allegation that Defendants, George Payne, Jr., Wayne Payne, Dianne Gatson-Riley, and Steve Campbell, "participated, encouraged, authorized or acquiesced in the existence and continuation of the deprivation of civil right, injurious abuse of and injuries to inmates including Plaintiff".

A. For each such document and/or communication, whether oral or written provided above, please describe with specificity how each document and/or communication relates specifically to George Payne, Jr., Wayne Payne, Dianne Gatson-Riley, and Steve Campbell.

RESPECTFULLY SUBMITTED, this the 2nd day of February, 2009.

GEORGE PAYNE, JR., DEFENDANT

BY: DUKES, DUKES, KEATING & FANECA, P.A.

BY: Cy Faneca
CY FANECA

CERTIFICATE OF SERVICE

I, CY FANECA, do hereby certify that I have this day sent via U.S. Mail a true and correct copy of the foregoing to the following:

Counsel for Plaintiff:
Robert G. Harenski
1906 Pass Road
Biloxi, MS 39531

Counsel for Harrison County:
Joseph R. Meadows, Esq.
Post Office Drawer 550
Gulfport, MS 39502

This, the 2nd day of February, 2009.

Cy Faneca
CY FANECA

CY FANECA, MSB #5128
HALEY N. BROOM, MSB #101838
JOE C. GEWIN, MSB #8851
DUKES, DUKES, KEATING & FANECA, P.A.
POST OFFICE DRAWER W
GULFPORT, MISSISSIPPI 39502
TELEPHONE - (228) 868-1111
FACSIMILE - (228) 863-2886

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
	P.O. Drawer W, Gulfport, MS 39502
Dukes, Dukes, Keating & Faneca	

I want this information released because:

Pending litigation.
(There may be a charge for releasing information.)

Please release the following information:

- ____ Social Security Number
- ____ Identifying information (includes date and place of birth, parents' names)
- _x_ Monthly Social Security benefit amount
- _x_ Monthly Supplemental Security Income payment amount
- _x_ Information about benefits/payments I received from _____ to present
- ____ Information about my Medicare claim/coverage from _____ to _____
  (specify) _____
- _x_ Medical records
- _x_ Record(s) from my file (specify) All other reports, determinations, applications, and supporting documentation regarding my claim for, receipt of, administration of benefits and my eligibility for continuing benefits.
- ____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)
Date: _____ Relationship: _____

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?
Print the Name, Social Security Number (SSN), and date of birth below.

Name: _____ Social Security Number: _____

Other Name(s) Used:
(Include Maiden Name) _____ Date of Birth:
(Mo/Day/Yr) _____

2. What kind of information do you need?

____ **Detailed Earnings Information**
(If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

_____

_____

____ **Certified total Earnings for Each Year**
(Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004. Request for Earnings and Benefit Estimate Statement) For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3. . . . . A. $_____

Do you want us to certify the information? ____Yes; ____No.

If Yes, enter $15.00 . . . . . .B. $_____

ADD the amounts on lines A and B and enter the Total Amount. . .C. $_____

* You can pay by CREDIT CARD by completing and returning the form on page 4
or
* Send your CHECK or MONEY ORDER for the amount on line C with the request, and make check or money order payable to "Social Security Administration."
* DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

SIGN your name here:
(Do not print) _____ Date: _____

Daytime Phone Number: _____
(Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name: Dukes, Dukes, Keating & Faneca, P.A
Address: Post Office Drawer W
Gulfport, MS 39502

6. Mail completed Form(s) to:

Social Security Administration
Office of Central Operations
Post Office Box 33003
Baltimore, Maryland 21290-3003

Form SSA-7050-F4 (6-99)

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

Name: **William David Seal**

Date of birth: **August 20, 1955**

Social Security Number: 435-70-3991_____

I hereby authorize all health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, pharmacies, Social Security Administration Disability Determination Services and Department of Workers' Claims, to release all psychotherapy note records and information regarding Frances Winn, to the records service of Cy Faneca, Dukes, Dukes, Keating and Faneca, P.A., P.O. Drawer W, Gulfport, MS 39502.

I understand that this authorization is for release of psychotherapy notes as defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501 *[psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record].*

I, the undersigned individual am on notice that:

- Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.
- Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- This authorization can be revoked through written notice to Frances Winn, or to the individual above listed entities, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.
- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until settlement or final disposition of **William David Seal v. Harrison County, Mississippi, et al.** or five (5) years from the date of this authorization, whichever comes later.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Date: _____ _____

(Signature) Patient or Patient Representative

_____ _____

Printed Name of Patient's Representative Relationship to Patient

_____

Description of Representative's Authority to Act for the Patient

SWORN TO AND SUBSCRIBED BEFORE ME, this the_____ day of _____, 2009.

_____

NOTARY PUBLIC

My Commission Expires:

_____

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

**Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress date.*

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize_____ to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requestor Name: Dukes, Dukes, Keating and Faneca, P.A.
P.O. Drawer W
Gulfport, MS 39502

Patient Name: William David Seal
Patient DOB: August 20, 1955
Patient Social Security Number: 435-70-3991
Patient Address: c/o Robert G. Harenski, Esquire
1906 Pass Road
Biloxi, MS 39531

Disclose the following PHI for treatment dates (08-20-55) to Present.

☒Abstract/Pertinent	☒History and Physical	☒Physician Orders	☒Entire Chart
☒Operative Report	☒Progress Notes	☒X-ray	☒Billing
☒ER Report	☒Lab	☒Consult	
☒Other specified	☒Discharge Summary	☒Nurse Notes	

☒Other Specified: All other such records in your possession, custody or control.

The above information is disclosed for the following purposes:
☐Medical Care ☒Legal ☐Insurance ☐Personal ☐Other

____ I acknowledge, and hereby consent to such, that the release of information may contain alcohol
initials and drug abuse, psychiatric, HIV or genetic information

This authorization shall expire upon this expiration date: final disposition of **William David Seal** or five (5) years from the date of this authorization, whichever comes first
**If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to _____. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.

_____ _____
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of Witness Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of Witness Date

SWORN TO AND SUBSCRIBED BEFORE ME, this the_____ day of _____, 2009.

_____
NOTARY PUBLIC

My Commission Expires:

_____

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

EMPLOYMENT AUTHORIZATION

TO WHOM IT MAY CONCERN:

This authorizes any employer by whom I have been employed or sought employment, any labor union of which I am or have been a member, and any state or federal employment agency or commission, to furnish full and complete information hereby requested to the law offices of Dukes, Dukes, Keating and Faneca, P.A., or to any representative, attorney, or investigator from said office, including all employment information, employment applications, personnel files, information pertaining to my wages, and other related matters.

I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof.

Your full cooperation with the said attorneys is requested. You are further requested to disclose no information to any other person without written authority to do so.

ALL PRIOR AUTHORIZATION IS HEREBY CANCELED.

_____

William David Seal

Social Security Number: _____

Date of Birth: _____